# Section 125 FSA Claim Form

## THIS FORM MUST ACCOMPANY EACH GROUP OF RECEIPTS SUBMITTED

Employer: _____

Employee Name: _____ Soc. Sec. #: _____
Last First MI

Home Address: _____ _____ _____ _____
Number/Street City State Zip

Daytime Phone: _____ ☐ **Please check if new address**

### The following reimbursement request rules apply:

Healthcare and/or dependent care expenses must be **incurred** within the appropriate Plan Year and prior to reimbursement. Photocopies of receipts are acceptable. Please retain a copy of all receipts for your own records. Cancelled checks are not acceptable receipts. **This form must be signed and accompany each group of receipts submitted.** You may submit receipts by mail or fax.

**Healthcare receipts** must be from an independent third party and must include the following information:

- **Name of Provider**
- **Type of Service/Supply Provided (Names of Prescriptions required)**
- **Date of Service/Purchase**
- **Charge for Each Service/Supply**
- **Name of Patient**

Expenses that may be covered by your (or your spouse's) medical, dental or vision plan **must** first be submitted to the appropriate insurance carrier. The Explanation of Benefits (E.O.B.) you receive from your insurance carrier may then be submitted to *KBA*™ as a qualifying receipt toward your *KBA*™ Plan.

**Number of Health Care claims attached** _____

**Total dollar amount to be applied to your *KBA*™ Health Care FSA account $**_____

**Dependent Day Care receipts** must include the following information: Name of Provider, Date of Service, Name of Dependent and Fee for Service OR have your Dependent Day Care provider complete and sign below (original signature required).

Dependent's Name _____ Date of Birth _____/_____/_____

Dependent Day Care Provider _____ Tax ID or SSN _____

Dates of Service _____/_____/_____ through _____/_____/_____ Total Amount $_____

_____ _____
Dependent Day Care Provider Signature Date

**Number of Dependent Day Care claims attached** _____

**Total dollar amount to be applied to your *KBA*™ Dependent Day Care FSA account $**_____

To the best of my knowledge and belief, my statement in this Request for Reimbursement is complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. If this claim includes medical expenses, I certify that these expenses have not been previously reimbursed nor will I seek reimbursement from any other source. I authorize my Flexible Spending Account(s) be reduced by the amount requested.

**Attention *Flex Convenience* MasterCard users:**

- ☐ **None** of the attached claims were purchased using the *Flex Convenience* MasterCard
- ☐ **Some** of the attached claims were purchased using my *Flex Convenience* MasterCard (Please write "FlexCard" on claim(s) purchased with your *Flex Convenience* MasterCard)
- ☐ **All** of the attached claims were purchased using my *Flex Convenience* MasterCard

**Employee's Signature** _____ **Date** _____

**Please submit this form & receipt(s) by Mail:**
**KBA Flex Dep't / Qual Plans Division**
P.O. Box 55210
Indianapolis, IN 46205-0210

**Or submit via by Fax:** **317-284-7269**, or **866-241-1488**

Questions about this form? Contact *KBA* Customer Care at 317-218-1300 or toll-free at 866-387-0493.



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